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ABSTRACT

A family system is intimately affected by the presence of an alcoholic within the system. One symptom of alcoholism is the development of elaborate defenses. In response to the defense of the alcoholic, each family member develops individual well established and unique defenses. The diagnosis of the defenses is essential in determining the nature of the family illness and its treatment. Common roles found in families with an alcoholic include the Dependent (alcoholic), Chief Enabler (spouse), Family Hero, Scapegoat, Lost Child and Mascot (children). Just as the family unit adapts to the presence of an alcoholic, so must members adapt to the recovery process. Treatment of family members can begin concurrently with treatment of the alcohlic or independent of his/her admission to treatment. The therapist sets goals which advance healthy family functioning, because the pathology of alcoholism has undermined personal relationships, denied intimacy, and aroused many negative feelings. Each family member needs to receive treatment which will enable him to recognize his own defensive behavior, become aware of family interactional patterns, restore honest emotional expression, and increase his feelings of self worth. (Author/NRB)

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Identifying Alcoholism in Families Seeking Mental Health Treatment

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Alcoholism is an illness which permeates our society, resulting in disability and despair for untold millions. It has permeated our society so profusely that nearly every member has witnessed its effects - deterioration of lives and relationships, confusion and despair.

It is a disease for which there is a substantial body of information. The contribution to our understanding of alcoholism has grown greatly and much is available today. There is no doubt, however, that countless questions still remain unanswered.

If, indeed, alcoholism affects many, and a wealth of information is available about the disease, how does it happen that such a small percentage of people are diagnosed and treated for the disease of alcoholism? The answer lies in part to the lack of recognition of alcoholism by traditional health care personnel. Within these groups, the mental health practitioner plays a pivotal role in providing accurate diagnosis and referral/treatment for victims of the disease of alcoholism and their families. A current confound is the preparation of counselors. Traditional counseling curricula are void of any substantial information on alcoholism. The counseling practitioner, therefore, may be schooled adequately in counseling theories, but lacking in formal training in this crucial disease.

There are specific symptoms of this disease which render it diagnosable, and it can be treatable through a specific methodology. What is most damaging, is the clinical practitioner's misconceptions of this illness. What follows is a continuation of excessive drinking, as the practitioner struggles to find a supposed cause which instigates

the drinking. For example, he/she may treat communication problems related to marital discord and acting-out behaviors of the children. Therapy may continue for years, but due to the progressive deterioration of this disease, little improvement will be shown. The practitioner must understand the disease for what it is, as well as try to understand the individual circumstances of the people whom he/she is trying to help.

The purpose of this paper is to introduce some information which may facilitate more accurate diagnosis and more appropriate treatment for the disease of alcoholism. It includes information about the victim who is suffering from the disease and the deleterious effects of this disease on each family member.

It is the authors' hope that more counselors will become adept at recognizing alcoholism and treating it successfully. To this end, this paper provides information relevant to the diagnosis and treatment of alcoholism in clients seeking mental health services, since early diagnosis and treatment may provide more favorable outcomes for those suffering from this disease.

SYMPTOMS OF THE DISEASE FOR THE VICTIM

In the initial stages of alcoholism, the Victim drinks more than he/she used to drink on a particular occasion -- on the assumption that "he can handle it". This is often interpreted as "being a man" or "being cool". It is also a sign of increased tolerance. The ability to drink more than most people is generally one of the first signs of alcoholism. (Reilly, 1974).

A pattern which often follows is an increase in the number of drinking occasions. This is accompanied by rationalizations, or excuses, for the more frequent drinking episodes -- "It's Friday night", "It's a football game - everyone's drinking", "My wife is such a nag, I deserve to drink". These are comments often heard. Few people realize this may signal the beginning stages of alcoholism.

The general public lacks the knowledge of the above symptoms as the first signs of the disease. In fact, few mental health counselors would recognize these signs as potential symptoms of alcoholism. Therefore, it is not surprising that our society is unaware of these signs if those who "understand human behavior" do not know the signs of alcoholism. For many, these signs are not evidence of alcoholism but, rather, are considered to be "normal social drinking". Others, more enlightened, may identify this as alcohol abuse. The authors concur that this is alcohol abuse. People who experience the above patterns of drinking may never become alcoholic. Their abuse may be limited. It may never create problems in their lives - social, emotional, physical. However, the above symptoms may be evidence of the beginning stages of alcoholism. Alcoholism begins with alcohol abuse for every Victim who contracts the disease. It is impossible to tell whether the excessive drinking is,

or is not, alcoholism at this point. There can be no doubt that such a person may be experiencing the first stage of alcoholism.

It may be years after the emergence of the initial symptoms that the Victims or their families seek help. The Victim will have had numerous other symptoms in the interim, but at the time of seeking help, both the Victim and his/her family may be very confused concerning the symptoms.

The following is a typical profile of a person with the disease of alcoholism who is seeking Mental Health treatment. This profile is not all-inclusive, nor does every individual experience all of the symptoms. However, the profile would apply to many clients. In fact, many differences between clients may be attributed to different stages of the disease, rather than to a difference in patterns. The typical profile is:

A person who has been drinking excessively - often over a period of many months and years. The drinking may be sporadic - once a week or less often. It may be nearly everyday. What is significant, is that when they drink, they cannot control how much they drink. (Reilly, 1974). Control may be attempted through pledges, rules, etc., but eventually, each are violated. Blackouts (inability to recall past events) have occurred, but are not always reported. Personality changes begin occurring during intoxication. Relationships between family members, friends, and co-workers begin deteriorating. Financially, problems mount - especially if the Victim is the breadwinner for the family. Accidents - whether automobile, on the job or in the home - may increase. Possibly binge drinking occurs. These behaviors bring much guilt and shame. Psychological defense mechanisms emerge to deal with the unpleasant feelings associated

with these behaviors. These defense mechanisms often become well developed, in order to cope with the continued drinking, and are a symptom of the disease, just as blackouts, family problems and binge drinking are symptoms. (Johnson, 1973).

One inevitable defense mechanism is the aggressive denial of a drinking problem. Despite the obviously alcohol-related problems, the person who has the disease cannot see this relationship. The Mental Health practitioner must anticipate this denial. The client with an alcohol problem cannot accurately identify his/her alcohol-related behavior. His/Her perception is that his/her drinking is not a problem and does not cause problems. This is a delusion. The reality is that the drinking is unquestionably a problem and, in fact, is at the root of many problems. At the time they are seeking help, clients do not know this.

The defense mechanisms are many - another is rigidity about when, where and what the client drinks. (Reilly, 1974). In attempting to prove that they do not have a problem with alcohol, they may become preoccupied with the rules about their drinking behavior - "I only drink beer", "I never drink on the job". Their definition of an alcoholic will never include themselves - "It's someone who drinks the 'hard stuff' - like my dad", "It's someone who really needs it. I don't need it. I just drink on weekends - because I want to".

In time, the Victim's personality becomes reshaped by the delusional processes of denial and rationalization. (Wegscheider, 1978). They become hesitant regarding commitments toward others. They move away from taking responsibility for their actions, their feelings and their thoughts. They attempt to compensate for inner feelings of guilt, shame and contempt by pretending joviality, making grandiose plans, or seeking

perfection in their work activities. They develop pseudo-standards of performance both for themselves and others. One delusion builds on another until their functioning is seriously impaired.

Due to the nature of the disease, the excessive consumption of alcohol continues. Much to the delusion of the Victim, control is impossible. This is likewise the delusion of the family members. Their endless hope is that someday the Victim will be able to control his/her drinking.

SYMPTOMS OF THE DISEASE FOR THE FAMILY MEMBERS

The disease of alcoholism affects its Victims and their family members in every realm of life. Initially, the disease subtly affects the spouse. Gradually, children become aware of the problems which are the result of the drinking. (Wegscheider, 1976). In time, the family becomes dysfunctional and the effects extend beyond the family unit - to in-laws, neighbors, co-workers and friends. Indeed, the effects of one person's alcoholism extend to society as a whole. How many individuals are killed in automobile accidents, never having known the Victim of this disease who killed them? This paper focuses only on the effects on the Victim and his/her "typical" family. However, generalizations of these effects can be extended to all individuals who have contact with a person who has the disease of alcoholism.

THE ENABLER SPOUSE

As the Victim experiences the symptoms of alcoholism, the family members have a response to each symptom. The family member closest to the person with the disease is usually the spouse. He/She provides the initial response to the growing symptoms. The term "enabling" has been used by the Johnson Institute to describe the response by the family. Therefore, the spouse is called the chief Enabler.

Enabling is defined as assisting or supporting. In a marital relationship, providing support or assistance is usually a healthy sign. However, in a family where alcoholism exists, this becomes perverted. The enabling spouse provides extra support and assistance which covers the growing disability of the Victim. This compensation is not a question of choosing to provide support. It is a compulsive reaction. The supporting, or enabling, minimizes the disruption caused by the Victim's behavior and encourages the Victim to continue drinking. (Wegscheider, 1976). Ironically, this is the opposite of their hope - that the Victim of the disease will stop drinking.

The various stages of development for the Victim are accompanied by a similar progression of stages for the spouse - the Enabler. At first, the Enabler attempts to protect the Victim from the ill effects of the drinking. Because of ignorance concerning alcoholism, the Victim and Enabler are greatly confused about what is happening. The Victim will utilize the defense mechanisms noted earlier in this article. This will provide a shield from the painful feelings associated with their behavior. The Enabler will respond to the Victim's defenses with a complementary defense. For instance, the Victim may claim that they became intoxicated because, "We're always broke and I worry about the bills". The spouse does not know that the Victim simply cannot control their drinking. Regardless of whether their income is $10,000 or $100,000, the Victim will drink. This lack of understanding about alcoholism is one of the fundamental problems in the perpetuation of the disease. The Enabler is confused about why the person is drinking. He/She begins to question it and begins to believe that maybe the lack of money is the problem. And he/she may agree that this drinking episode is really "my fault". Likewise, as

the Victim blames his/her boss for all the pressures at work, saying, "I just have to have a drink," the spouse responds with the complementary defense of "Yes, I understand". To them, there is no other logical explanation for the drinking.

As the Victim and Enabler defend against drinking as a problem, the defense of irresponsibility is a convenient one to employ. Their perception is that you could not expect someone who is irresponsible to have enough money to pay a bill on time. This would be an explanation to them as to why half of the last paycheck was spent on drinking. In a complementary style, the spouse becomes an individual who is extremely responsible. Eventually, the spouse may pay all the bills, take on a second job, rear the children and do the housework. The Victim will not be viewed primarily as someone who has a problem with alcohol but, rather, as someone who is irresponsible and lazy.

As the Victim loses more and more control over their drinking, their behavior and their feelings, the spouse attempts to take more and more control. For example, the spouse will attempt to control the Victim's drinking by pouring the alcohol down the drain, by drinking with them and telling them when they have had enough, or by turning down social invitations that would include drinking. Such attempts fail. It is impossible to control the drinking of someone with the disease of alcoholism.

The delusion of the Enabler is that they are taking care of the Victim. The reality is that are not even taking care of themselves. They are engulfed by the pathology of the disease. They are as out of touch with their feelings as the Victim is. The interactions between the Victim and Enabler become problematic and their relationship deteriorates to a survival level. The Enabler's self image is one of

worthlessness and helplessness. He/She lives in a chaotic world of which their spouse is the focal point. Both are unable to develop any separateness from the alcoholism which has infiltrated the family.

THE CHILDREN

Just as the Enabler becomes immobilized by his/her role in a family affected by alcoholism, so do the children. The longer alcoholism has affected the family, the more extreme and well-developed the roles are. The roles presented in this paper are based on the roles described in Wegscheider's The Family Trap (1976).

The model which will be used has four children in the family - all of whom are close in age. Obviously, this information will need to be adapted to fit most families. Attributes which are common to one role may be seen in several children of an eight-sibling family. Large age spans between siblings allows for several children to take a particular role. For example, the scapegoat child of age twenty would feel little competition from a scapegoat sibling of age four. The scapegoat behaviors would differ greatly due to age appropriate behavior. Also, as older children leave the home, younger children can begin to adopt the role of the person who left the home. Sex differences may account for role assignment. For example, if the oldest daughter is the second-born of several siblings, the responsibility for caring for the younger siblings may account for her taking the role of the responsible child. With many families smaller than four children, some roles may not be evidenced within a family, or two roles could be well-developed within one child. Therefore, the model simply describes four common roles found in children in which one family member is alcoholic. The names given to these four roles in Wegscheider's model are: Family Hero, Scapegoat, Lost Child and Mascot.

The identification of these roles serves a three-fold purpose. The process will lead to a framework for treatment - systemically and individually. Secondly, the extent of the dysfunctional development of these roles is usually an indicator of the severity of the disease - early, middle or late stage alcoholism. Third, it allows the counselor to expand the focus of treatment to include all those affected by the disease, regardless of whether or not the Victim attains sobriety.

More so than any other disease, the presence of alcoholism in one family member will result in a highly stressful environment. "Maybe she won't drink today", "You promised you would stop", "Where's Daddy? Is he coming home late again?", "Why is Daddy always sick?". These thoughts and words are indicative of the continual hope for change and the ever-growing disappointment and fear of what the future may hold.

The subsequent response to this mounting anger and confusion is the expression of a behavioral role designed to reduce the tension. (Wegscheider, 1978). Each family member plays a role which allows them to compete for attention. They are responding at an unconscious level with behaviors that have been conditioned over time as anxiety reduction techniques. (Black, 1979). They repress their feelings with no honest emotional communication. Far from resolving the dilemma, these behaviors actually support the drinking of the Victim. They serve to remove the focus from the drinking and displace it onto the other members of the family. Consequently, the drinking continues, unconfronted.

FAMILY HERO - The Hero is generally the oldest child in the family. It is this child to whom the family looks for a sense of success. One parent is bringing little esteem to the family due to the common

behaviors associated with alcoholism. The other parent is overwhelmed with endless responsibility for the care and survival of the family. Therefore, the Hero compulsively tries to help out and will be rewarded extensively for positive actions. In this family there is no opportunity for a child to express himself as a total person. Emotional expression is inhibited. The Hero is rigidly role-bound for good behavior only.

The Hero is not allowed to be a child. The Hero may be expected to assume some of the spouse/parental functions which were formerly performed by either parent. One example is a 12-year-old who cares for several younger siblings in addition to doing most household chores. The drinking parent is viewed as irresponsible, and the other parent is working two jobs. Another example of a Hero is the straight "A" student who is voted Class President and captain of the basketball team nearly every year.

This child has strong needs to do what others expect. He/She will compulsively perform at his or her best. Such children take undue responsibilities for the needs of others, while their own needs go unmet. Their behaviors are incongruent with their feelings. Yet, they persist in a fruitless attempt to control the parent's drinking. Just as the spouse believes "It's all my fault", the Heroes also have a response to the drinking. They begin to believe that if only they were more successful, then the parent would stop drinking. Thus an endless striving to do their best becomes life's mandate. Note that the Heroes attempt to "do" their best, not "be" their best.

The family supports and responds to this performance. The good behavior is reinforced for the transient relief it brings to the family. The Enabler comes to depend on the Hero as a primary source of emotional comfort. An alliance is formed - mutually and unconsciously - which will further isolate the Victim within the family system.

Heroes will often leave the family early to distance themselves from the chaos which exists. However, they carry their role with them. In order to play out the role, the Hero may leave with much fanfare to join the Army, attend college or enter religious life. There they continue an unconscious pattern of caring for others while denying themselves.

THE SCAPEGOAT - The Scapegoat role is often adopted by the second born. The behavioral manifestations of this diagnosis are opposite those of the Hero. Where the Hero brought a sense of worth to the family, the Scapegoat is the barometer of the family's pain. The more stress being experienced, the more deviant the behaviors expressed by this child.

Inordinate attention is given to the Victim and his/her drinking. The Enabler attends to this and assumes excessive responsibilities for the survival of the family. There is little affirmation for the children. Only highly noticeable behaviors are attended to by the parents. The Hero has found visibility through outstanding achievement and success. It is easier for the Scapegoat to be noticed for deviant behaviors than to compete with the Hero for the attention for good behaviors.

The Scapegoat's acting-out will be at the same level of intensity as the role expression of any other family member. Thus, systematically, some of the focus is taken off of the Victim who is drinking. For example, if the Victim goes on a binge episode, the Scapegoat will respond with a comparable level of misbehavior. Possibly, this would be running away from home or shoplifting. Interestingly, if the Hero achieves some significant goal within his/her role, such as receiving the lead in the school play, the Scapegoat will then compete for some

attention with an acting-out behavior of equal magnitude. To the extent that the Hero is "such a good child", the Scapegoat is "such a bad child."

Within the family there is little attention left to be given the Scapegoat. However, attention can readily be received through the peer culture. In a search for belongingness, values of the peer group are adopted. The Scapegoat will potentially emerge as leader among this group.

Accompanying the attraction to the peer group, drug use is common through the adolescent years. The good feelings elicited through the use of alcohol or other mood-altering chemicals provides relief from their displacement by the family. These feelings can mistakenly be attributed to the good feelings of being with "friends." However, if the chemical use is extensive, it is unlikely that open, honest relationship-building has occurred at all. But the attraction to the peer group inclusive of drug use is preferable to what is offered by the home environment.

A primary feeling coupled with the deviant behavior is that of rage. The child suffers alone and against the wrath of society. The Scapegoat's behavioral expression is shaped for deviance. This is not necessarily the conscious choice of the child or the family. It is engulfment by the roles which inevitably emerges as one member experiences the disease of alcoholism.

The future for these children is not inviting. Their past is characterized by conflict, interpersonal distrust and alienation. Their prognosis is guarded. They enter adulthood with unresolved feelings of rage, fear and distrust. Not having enjoyed acceptance, they reject others and adopt a survival lifestyle.

Scapegoats leave the family early - and with scapegoat-like qualities. They may marry at a young age due to pregnancy. Possibly they leave home by order of the courts to a foster placement, detention center or jail. Some die - victims of their own risk-taking.

LOST CHILD - As the Victim's relationship with the bottle grows, the less interpersonal relationships can thrive. The Hero and Scapegoat maximize their roles in a family which now exists on a survival level. Therefore, the third child matures unnoticed and forgotten. The family is pleased with this invisibility. The child does not cause trouble and does little that requires attention. The parents are glad not to have to "worry about the child". There is no attempt by this child to compete with the older siblings. The withdrawal is supported by every family member. This child becomes the "Lost Child".

The Lost Child's world is a solitary one. The child adapts to the lack of interaction and concern, tending to compensate by developing an interest in things - toys, cars, books. Spending time alone becomes preferable to entering the chaos of the family system. The child frequently daydreams and escapes into fantasy-like worlds. What can be created in their mind is more rewarding than what can be attained through relationships within the family since familial relationships are rejecting. There is no expression encouraged - whether emotional, intellectual or social - just a silent forlornness exists for this child.

The family functions the same regardless of the presence of this child. The child is often not included in activities and is usually "left in the dark" about family concerns or events. The child does not complain since little else is expected. For a glimpse of emotional attachment, this child will usually adopt a neighboring family down the street. His/Her absence is largely unnoticed by the family.

This well-ingrained role expression goes beyond the family to the school, work and community environment. In school, this child has few friends. The Lost Child comes without notice, does the work and quietly goes home. His/Her life is lived out in an obscure mode. For example, in an attempt to name all the members of a class or group, it is this child who is forgotten - or the last to be remembered. A teacher will usually not remember this child's name from the class just the previous year. Such children seem to lack distinguishing characteristics.

The hallmark feeling for this Lost Child is loneliness. It is repressed and not expressed. The role the child adopts assumes an outward acceptance of this distance from people. This child does not even attempt to be close to another, and nothing is expected of this child. There may not be criticism given, but no praise is given, either. In this silent existance, the child feels worthless.

The Lost Child will probably choose a career with few opportunities for social interaction - a mechanic, a computer operator, a reclusive writer. In a community, this person would be the neighbor no one knew. This person automatically withdraws from interaction with people. Their fear of rejection could lead to the ultimate withdrawal - suicide.

THE MASCOT - Frequently, the youngest member of the family assumes the role of Mascot. At the time of their arrival, the family may have been experiencing the effects of alcoholism for many years. The dysfunctional nature of the family demands some unique characteristics from this youngest member.

With keen competition for attention present, the Mascot must be aware of the happenings in the family. Despite being developmentally behind the other siblings, his/her survival calls for an

ability to command attention. This is often accomplished through the development of comic ability. The Mascot seems aware of the perfect timing for charm, wit and excessive activity. They become masters of distraction.

Within this role, the Mascot also brings some superficial relief to the family. When the dependent parent begins his/her drinking episode, the Mascot responds to relieve some tension. This may include telling jokes, acting cute or silly. These behaviors take the focus off the drinking and enable it to be ignored by the family.

The Mascot is the child who is always laughing - whether or not there is a reason to laugh. His/Her laughter is to gain the appeal and attention of others - it is never an expression of sheer enjoyment. Also for appeal, the Mascot may be prim and proper in dress and manner. This child is "such a little lady or gentleman". The payoff is the attention.

The Mascot will never be able to attain adult status. He/She will always be considered "too young to understand". Feelings of confusion will emerge as the Mascot attempts to live out an adult life since he/she was never prepared. Despite the facade of enjoying life and having a good time, the loneliness prevails because no one really knows this child.

The family that presents itself for treatment is seriously disabled. The progressive nature of alcoholism moves the Victim and family along an addictive continuum. The more chronic the alcoholism, the greater the emotional and physical damage. A gradual erosion of the family's vitality is experienced. Each member attempts through his/her role to counteract the growing deterioration. Communication within the family becomes dominated by problem topics. The delusional

process accompanying alcoholism encourages withdrawal and helplessness. Emotions become blunted. Feelings of anger and/or indifference emerge as primary feeling states. The Victim and family gradually lose their ability to take corrective action. They respond behaviorally with diversion instead of problem solving. They desperately work to avert the collapse of the family. (Black, 1979).

TREATMENT OF ALCOHOLISM FOR VICTIMS AND THEIR FAMILIES

Unlike many illnesses, the suffering which accompanies alcoholism is usually misperceived as being caused by other stressors. This is a unique characteristic of addictive illnesses. In conventional illnesses, the Victim and/or family members are better able to describe their symptoms and formulate a tentative diagnosis. Someone who suffers from a cough or a rash is usually able to recognize this as a symptom of an underlying physical condition. These complaints are then offered informationally to an attending physician or helping professional. However, with alcoholism, the denial system, lack of information and misinformation about the illness, perpetuates a jumbled perception of the problem. The individual or family discounts the psychophysiological effects of drinking, and, instead, searches desperately elsewhere for a causal factor. Their search leads them to identify multiple problems of a personal, social or economic nature which they believe explain the excessive drinking. All of these become useless over time. The Victim is drinking simply because he/she has become dependent on alcohol.

This confusing situation is further exacerbated by the failure of uninformed professionals who prescribe conventional remedies targeted at the symptoms rather than the disease. If any improvement in health is noted, it is undoubtedly transient. In fact, the alcoholism may increase in severity in response to misdirected chemotherapy and

psychotherapy. (Bassuk, 1977). Thus, the slowly evolving system of failure, disillusionment, distrust and confusion becomes well-ingrained.

The goals of treatment must address this insidious and deteriorating condition. Such a family needs the services of an individual who is aware of the nature of alcoholism and has insight into the ability needed to work with this clientele. A therapist who treats alcoholism must be knowledgable of the disease, or should be under the close supervision of a senior alcoholism counselor. The therapists must know their strengths, as well as their limits in the treatment process. And, when facing their limits, they must know how, when, and why a referral is necessary. A sense of hope for successful treatment must emanate from the counselor. Without these essential features, the therapy becomes misguided and useless.

The primary tools available to the counselor in the treatment of alcoholism include the following:

1. Therapeutic Use of Self
2. The Helping Interview
3. Knowledge of the Illness
4. Utilization of Community Resources

Each of these is indispensable to the treatment plan. The absence of one or more of these tools will create a deficit capable of defeating the intervention. These four tools will be clarified here in terms of their role in the healing process.

1. THERAPEUTIC USE OF SELF

The counselor as a person is a dynamic force within the treatment process. His/Her relationship with the entire family is critical for a successful plan. However, sensitivity to the families' plight as it experiences this disease may not be easily developed. The counselor

is culture-bound. His/Her clinical training, personal experiences and convictions have been formed in a society that has traditionally regarded the use of alcohol ambivalently. On one hand, our society encourages drinking as a socially appropriate activity. Simultaneously, it teaches condemnation of the person who has lost control of his/her drinking. The general belief that alcohol is an acceptable beverage, instead of a drug, leads us to perceive problem drinking as a free-will act. We deny the addictive potential of alcohol. We ignore individual biochemical sensitivities and assume a deviant "psyche". It is not by choice that the Victim drinks beyond control - the nature of addiction generally precludes control. Yet, society blindly condemns the problem drinker and is careful to exclude any inference of disease.

Additionally, within the social science literature, the simplistic view that alcoholism is merely a behavioral response to an underlying condition further obscures pertinent facts. It belies our knowledge of addiction and mimicks the cultural prejudice. Authors have theorized that drinking is merely a response to anxiety or depression (Bowen, 1974), an attempt at self-medication. This addresses only the most superficial aspects of alcoholism. Unfortunately, the confusion present in our society concerning this disease has been internalized by many researchers and counselors as well.

We must become aware of these convictions and prejudices. We must identify their manifestation in our therapeutic style. The cultural prejudices are so subtle and yet pervasive that they can form a major barrier to the therapeutic use of self.

The counselor would do well to ask himself/herself what feelings and attitudes are evoked by the word "alcoholic". If the response

conjures a negative image, the counselor should seek additional sensitization and preparation experiences. Attendance at Alcoholics Anonymous meetings, continued training at an institute for alcohol study, reflection on personal experiences with Victims of this disease and continued readings of alcohol-related literature are recommended. Also, the counselor must develop the ability to identify crucial components of diagnosis and treatment. This preparation will include a knowledge of the chemical, its physiological effects, a recognition of symptoms and the process of physiological, psychological and social adaption which occurs in the progression of the illness.

Lest the counselor discount this self-analysis or preparation, let us state the magnitude of the illness which confronts him/her. Alcoholism follows heart disease as this nation's leading killer, claiming an estimated 250,000 lives each year. Those are the death statistics. Estimates regarding the number of Victims of alcoholism approximate 10 to 15 million individuals in the United States alone. These people have families, jobs and communities - all affected by the alcoholism. The economic loss of some 43 billion dollars annually is attributed to alcoholism. While this is secondary to the suffering of the Victims, it is nonetheless staggering. (U.S. Jour. D.A.D., 1980).

This devastation can be compounded by clinicians who fail to obtain adequate training in alcoholism counseling. A treatment plan which fails to address the critical areas of physiological and psychological dependency is inadequate. One that assumes psychosocial causality is prejudiced. A misdirected treatment plan only further obscures the vision of recovery and prolongs the suffering.

2. HELPING INTERVIEW

The helping interview is another tool which must be maximized by the counselor. Its goals are three-fold. The counselor must seek to

establish a positive relationship with each family member. Second, the presenting problem and underlying alcoholism problem must be defined in a solvable way. Third, a workable treatment plan for each family member must be implemented. The therapeutic interview should be structured by these three overlapping tasks. The support, intensity and confrontation generated during the interviews must be guided by the counselor's sense of the individual's and family's readiness. Movement toward these three goals marks the progress of the treatment.

ESTABLISHING THE RELATIONSHIP - An understanding of the roles presented earlier in this paper gives the prepared practitioner a unique and decisive advantage in establishing a meaningful relationship and credibility. Initially, the family system can be joined by the counselor quickly, due to the counselor's ability to read the family's structure and to design a therapeutic niche from which to operate. The counselor must begin to establish rapport with all family members. This is a challenge. An attempt to cultivate a relationship with one member may alienate another member. Maintenance of this vital balance is the goal. However, during the initial interviews, it is crucial to engage the individual who is the decision-maker in the family, for it is this person who will decide whether or not the family will continue counseling.

Dismantling the "no talk" rule within the family is a significant task. This requires the practitioner to establish himself/herself as the therapeutic authority. The development of authority should not rest with the use of power. Authority is developed by knowing what to do and when to do it. By effectively establishing empathy and reflecting accurately the thoughts and feelings of the family, the practitioner builds authority within the family. The empathy is

bolstered by the practitioner's knowledge of the symptoms and nature of alcoholism as well as the family dynamics. From this position, the counselor is able to verbalize affective expression for the Victim and family members. This will expose the underlying feelings trapped beneath the defensive behaviors.

Once exposed, the family will sense ambivalence in their feelings in favor of disclosure and the need to protect themselves from disclosure, since disclosure may lead to disappointment and failure. Since the family has been hurt and frustrated countless times, it is frail and inherently resistant to further emotional risk. Knowledge of this resistance should prevent the practitioner from initially overemphasizing the many emotions present in the family, and help to develop further the family's ability to solve problems.

DEFINING THE PRESENTING PROBLEM - Usually the family will present a problem child - the acting-out of the Scapegoat or the hyperactivity of the Mascot, or possibly recurrent depression by the Enabler or Victim will be presented. There may be mention of a member who has "a problem with alcohol" but the family will quickly refocus on their identified problem. The presenting concern must be addressed by the counselor in a pragmatic and successful way prior to the confrontation regarding the alcoholism. Without this introductory stage, the counselor will fail to establish himself/herself as credible and helpful. The interview will become intimidating and further alienate a frightened and insecure family. Focusing on a presenting problem and redefining it in a solvable way will allow the counselor to become established within the family system. This redefinition must include positive developmental features which will give the family a sense of hope. It must refocus the family's efforts toward health.

An example of redefinition would be the framing of pseudo-hyperactivity within the Mascot as "low cost energy" capable of being rechanneled into sports and hobbies. Depression may be redefined as "intolerance of the present situation". Using this framework, the family will experience a positive problem-solving approach. It will increase the members' understanding, affect and self-esteem. It will also expand their appreciation for the counselor.

This stage of therapy should strive to be corrective so as to provide some relief. Therapy must be seen as a healing process. This action sets the stage for the identification of alcoholism within the family.

DEFINING ALCOHOLISM AS THE FUNDAMENTAL PROBLEM - After the family has experienced the practitioner's empathy and willingness to solve their presenting problem, the opportunity exists for the counselor to share his/her concern about the alcoholism in the family. This should be orchestrated with the counselor meeting alone with the Victim and his/her spouse in the absence of the children. The practitioner should see the presentation of an accurate diagnosis as one of the most critical moments in treatment. The family's problem is being defined at the causal level. No one reaction can be expected. It may include denial, anger, relief or curiosity. Their denial may discount the diagnosis. They may project onto the therapist their repressed anger. They may cry from relief. Surprise and a guarded interest may be expressed. Whatever their response, the illness has been recognized and rendered treatable. At some level within the Victim and their spouse, the recognition will occur. The readiness for acceptance of the disease by one or both individuals will determine if further treatment is possible or if termination is desired. Whatever the outcome, the seed of recovery has been planted.

The practitioner must recognize the longitudinal nature of recovery. The journey from dependency to rehabilitation is a long one. It appears to occur in stages which are often punctuated by personal or family crises. The identification of alcoholism as the underlying problem is a critical juncture for this family. In the future, the many incidences of embarrassment, disappointment, physical discomfort and spiritual disillusionment may be affixed to their causal element. With each crisis the discomfort builds until the Victim or family members exceed their threshold of tolerance. The decision for wellness is pressed to the face of reality.

IMPLEMENTING A WORKABLE TREATMENT PLAN - The Victim and spouse may not respond immediately to a treatment plan, but the kernel of reality has been firmly implanted. Over time, a growing response to this message is developed. In many cases, the spouse will contact the counselor to seek further treatment for the family. The Victim's decision to join treatment often depends on whether or not a crisis is present. Changing the enabling behavior of the family members may also facilitate the Victim's entry into treatment. As family members continue in successful treatment, their enabling behaviors will lessen. Healthy, independent behaviors will be encouraged. These appear to be keys in unlocking the Victim's defensive posture long enough to engage him/her in a treatment program.

The preferred course of treatment for the Victim utilizes a hospital in-patient program. This is presently the most comprehensive and successful approach to problem drinking. (Johnson, 1978). The availability of medical personnel reduces the risk of detoxification and accompanying illnesses can be diagnosed and treated. The structure of these programs develops support and therapeutic intensity at levels

unattainable in out-patient settings. The opportunity for recognition of the illness and submission to its uncontrolled nature is facilitated by the group settings.

In some cases, the unavailability of in-patient programs - due to distance or economic restrictions - necessitates an out-patient program of recovery. This program should include: a medical evaluation, pledge for sobriety, education about alcoholism, counseling and support. Multiple meetings on a weekly basis are recommended. Referrals to Alcoholics Anonymous provide the Victim with a support group for identification and encouragement. The contact with successfully recovering persons within these groups provides role models and inspiration. This type of community assistance enhances rather than confounds treatment.

Relapse should be expected. The counselor must accept this condition. Movement back into sobriety is necessary if therapy is to continue. The Victim should be made aware of the consequences of his choice. Patience must be cultivated. However, the counselor must be on guard against manipulations by the client. A loss of sobriety is sufficient cause to postpone further sessions. Counseling can be reinitiated once another pledge for sobriety has been given.

Should the Victim refuse sobriety and treatment, the counselor must continue to pursue treatment for the children and Enabler. Freeing them from entrapment within their roles is a primary therapeutic goal. Alcoholism is a family disease. They will continue a maladaptive pattern of interaction unless intervention is begun.

The therapist can become a healthy ally for the Enabler. Counselors can provide support and an objective reality of the addictive process. The Enabler's unexpressed thoughts and feelings

toward the Victim can be worked through with the counselor. This will minimize their displacement onto the children. The Enabler can be taught the facts regarding alcoholism. Their struggle to compulsively control a deteriorating marriage can elicit empathy from the counselor. Their needs for security can be affirmed. They can experience with the counselor an intimacy which will penetrate the delusional organization of their thoughts. The guilt which accompanies alcoholism will dissipate as appreciation for themselves is reestablished. Referral to Al-Anon provides a reference group. Combining therapy with a support group increases the chance for recovery.

The children must be counseled to rediscover themselves. (Black,1979). They have matured into roles which restrict their expression. They act compulsively to prevent the family from collapsing. Their emotions have been blunted by resentment toward their parents and themselves. They have poor self concepts. These children survive in a chaotic and confused world of competition, emotional repression and often violence. They have few problem-solving skills. They witness little appropriate responsibility-taking. They fear to trust others, due to the countless interpersonal failures they have experienced within the family.

The treatment must address these children in a developmental way. (Ackerman, 1978). Their needs for security and an appropriate identity should be affirmed. Their self-interest should be developed. Productive, self-directed behavior can be reinforced by the counselor. Intimacy in relationships can be restored through affective expression and shared experiences. The plan moves forward longitudinally to compensate for early trauma. Health is restored.

3. KNOWLEDGE OF THE ILLNESS

There is no substitute for information and education about alcoholism. This applies both to the training of the practitioner as

well as the treatment plan of the entire family. The complexity of the illness is evidenced both by the physiological complication as well as the psychological aberations. Recovering from alcoholism is more than just a need for detoxification. It is more than the dismantling of psychological defenses. Alcoholism is an interaction between mind, body and environment.

Therefore, the presentation of relevant information must be part of the treatment plan. The ambivalence and fear nurtured by this illness are mitigated by the presentation of factual information on the disease. Alcoholism is a definable illness which, although incurable, is treatable. The members of this family need to be informed of the symptoms of the illness and be given the hope for successful treatment. (Homonoff, 1979). Excellent resources about the disease include literature from the National Institute of Alcohol Abuse and Alcoholism (NIAAA), Alcoholics Anonymous, The Johnson Institute and Hazelden Press. Bibliotherapy allows clients to work at their own pace. In time, their understanding grows. The availability of literature serves as an excellent complement to the education provided personally by the counselor.

Information should be blended with affective reflection so as to insure its personalization. Through self-help groups, the common experiences which are shared will facilitate awareness and insight. Understanding develops which replaces the moral condemnation and bitterness of past events. Forgiveness and resolution are the endpoints toward which all family members must strive. (Johnson, 1973).

4. UTILIZATION OF COMMUNITY RESOURCES

The utilization of community resources to strengthen personal recovery efforts is an important element in a successful treatment

plan. The deteriorating effects of alcoholism may have estranged this family from relatives, friends, church affiliations, employment opportunities and successful role models. The replacement of these vital components is necessary if an alternative life of recovery is to be viable. The sickness model remains potent in the minds of those on the brink of recovery. The need for successful role models evidencing health can be met through the use of Alcoholics Anonymous, Al-Anon, Alateen and Alatot. The stabilization of the economic condition may be achieved through intervention with aformer employer, referral to a vocational training program or an employment agency. Relatives and former friends can be contacted by the recovering family as they feel able to redevelop these relationships. The counselor must be cognizant of the importance of this effort and must plan for these events.

Finally, the practitioner might suggest to the family their reinitiation into a former church or religious group whose affiliation had been abandoned during the course of the illness. This recommendation can be made without trepidation due to the restorative theme of therapy. This theme emphasizes the reconstruction of their healthy former lifestyle. For many this will have included church participation. If not, then the suggestion may be framed as a recommendation for consideration without necessity.

SUMMARY

The nature of alcoholism is complex and dynamic. It affects not only the Victim but also the family of the Victim. The progressive nature of this addiction causes deterioration of the Victim's physical and emotional health. The family responds with compensating behavior which further aggravates the illness. A slowly deteriorating situation emerges to replace a once healthy and functional family system.

Intervention by trained counselors can initiate the process of recovery. To do this the counselor must recognize the symptoms of alcoholism. Often opportunities for treatment are lost because an alcohol problem is discounted in therapy as being symptomatic. Alcoholism is primary and problematic. Securing treatment for this chronic illness is important for the health of millions of Americans. The mental health counselor plays a pivotal role in providing this treatment. The need for additional training to accept this challenge is evident. Success in treatment will depend on the recognition of alcoholism as an addictive illness. Proper treatment should follow a course of planning designed to rehabilitate the Victim and his/her family.

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